**Trinidad and Tobago Insurance Limited**
11A Maraval Road,
Port of Spain,
Trinidad and Tobago, W.I.
P.O. Box 1004
Tel: 62TATIL (868) 628-2845
Web: www.tatil.co.tt
E-mail: info@tatil.co.tt

Tatil
... where people are people

# GROUP HEALTH APPLICATION FORM

***Note: All Sections are Mandatory.***

## SECTION A – EMPLOYEE INFORMATION

| | | |
|---|---|---|
| **Policyholder / Employer:** | | |
| **Name of Employee:** | | |
| **Nationality:** | **Occupation:** | |
| **Date of Birth:** MM/DD/YY | **Sex:** ☐ Male ☐ Female | |
| **Coverage**: ☐ Employee Only ☐ Employee & One Dependent ☐ Employee & Family | | |
| **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Common Law ☐ Separated | | |
| **Residential Address:** | | |
| | | |
| **Phone Numbers: (H)** | **(M)** | **(W)** |
| **Email Address 1:** | **Email Address 2:** | |
| **Identification (select one):** ☐ National ID ☐ Passport ☐ Driver's License<br>***please attach a copy of your identification*** | | |

## SECTION B – EMPLOYEE'S DEPENDENTS TO BE COVERED

| Name of Dependent(s): | Relationship | Sex | Student | Date of Birth |
|---|---|---|---|---|
| | Spouse | ☐ M ☐ F | N/A | MM/DD/YY |
| | Child | ☐ M ☐ F | ☐ Yes ☐ No | MM/DD/YY |
| | Child | ☐ M ☐ F | ☐ Yes ☐ No | MM/DD/YY |
| | Child | ☐ M ☐ F | ☐ Yes ☐ No | MM/DD/YY |
| | Child | ☐ M ☐ F | ☐ Yes ☐ No | MM/DD/YY |

***Please note that students between the age of 21 to 24 who are unmarried and fully dependent require a school letter indicating whether they are a full-time student.**

## SECTION C – COORDINATION OF BENEFITS

| **Are you or your spouse covered by any other medical plan? If "Yes":** | | | |
|---|---|---|---|
| | **Name of Plan/Group** | **Name of Insurance Company** | **Effective Date of Plan** |
| **Employee:** | | | MM/DD/YY |
| **Spouse:** | | | MM/DD/YY |

**SECTION D – BENEFICIARY INFORMATION**

| ***I hereby authorise TATIL to pay any health claims which may be due to me, in the event of my death*** | |
|---|---|
| **Beneficiary Name:** | |
| **Relationship to Insured:** | **Date of Birth:** MM/DD/YY |
| **Contact #:** | **National ID/Driver's Permit:** |

**SECTION E – ACCOUNT INFORMATION FOR PAYMENT OF CLAIMS**

| ***I hereby authorise TATIL to use the account information provided below to credit my account with any health claim reimbursement due to me or my dependent(s) under this policy*** | | |
|---|---|---|
| **Name on Account:** | | |
| **Bank:** Select One | ☐ First Citizens Bank Limited<br>☐ Scotiabank of Trinidad & Tobago<br>☐ ANSA Bank *(formerly Bank of Baroda)* | ☐ RBC Caribbean *(formerly RBTT)*<br>☐ Republic Bank Limited<br>☐ JMMB *(formerly Inter-commercial Bank)* |
| **Account Number:** | | |
| **Account Type:** Select One | ☐ Savings ☐ Chequing | |
| **Bank Branch & Transit #: Scotiabank Customers ONLY** | | |

**DECLARATION AND AUTHORISATION**

*I hereby certify that to the best of my knowledge the foregoing answers are true and correct and that I have not withheld any material information or suppressed any material fact.*

*I hereby authorise any physician, dentist or other practitioner, hospital, clinic, insurance company or any organisation, institution(s) or person(s) that has any records or knowledge of me, my spouse or my children, to give to Trinidad and Tobago Insurance Limited any and all information about me, my spouse or my children regarding conditions for which we have been previously under observation or treatment, including findings, pathology, diagnosis, and advise.*

*I understand and agree that any injury that occurred on or before the date of this application or any sickness, the signs of which first appeared on or before the date of this application, whether I am aware of a diagnosis or not, are considered pre-existing conditions and are not covered by this Policy unless fully disclosed on this application. I understand that failure to disclose such information could result in denial of a claim and the cancellation of coverage.*

*I understand and agree that Trinidad and Tobago Insurance Limited shall not be liable to refund any premiums submitted should the coverage be rescinded as a result of non-disclosure of information.*

*I understand that completion and submission of this application does not represent automatic enrolment nor guarantee eligibility for coverage under this Policy. I further agree that coverage shall not become effective until approved by Trinidad and Tobago Insurance Limited.*

| | |
|---|---|
| **Employee's Signature** | **Date:** MM/DD/YY |

**SECTION F – TO BE COMPLETED BY EMPLOYER**

| **CHECKLIST (to ensure the timely completion of this application, the following items must be attached where applicable)** | | |
|---|---|---|
| ☐ Marriage/Common Law Certificate | ☐ Student Letter for Dep. Age 21 to 24 | ☐ Birth Certificate for Children |
| ☐ Copy of Identification | ☐ Copy of Bank Statement | ☐ EOI (if applicable) |

| **Date Employed:** MM/DD/YY | **Date Confirmed:** MM/DD/YY | **Effective Date of Insurance:** MM/DD/YY |
|---|---|---|

| **Employer's Stamp:** | **Plan Administrator Signature & Date:** |
|---|---|

| **TO BE COMPLETED BY TATIL** | |
|---|---|
| **Effective Date of Employee's Coverage:** | **Class/Coverage:** |
| **Enrolment ID:** | |
| **Rider:** | |
| **Underwriter's Signature:** | **Date Completed:** MM/DD/YY |